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When Caregivers Cease to Care

by

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Abuse of the Elderly: When Caregivers Cease to Care

by Elizabeth Podnieks

"I myself am an only daughter and my life is becoming a wreck because of looking after old people for the last ten years. At the moment, I am looking after my mother, who suffers from senile dementia and is at times like something out of a Dickens mad house. On two occasions in the past, I have slapped her, but now I have my feelings under control and I go out and sit in the car with the radio on and scream."(1)

Caregiving, even in the best of circumstances, is not easy. Families struggling to meet the needs of aging, ailing relations may reach the point where the strain becomes unbearable. This can result in a situation which Eastman describes as "caring, coping, and eventually collapsing."(2)

Due to changing demographics many middle aged or older, adult children are faced with the responsibility of parenting their own parents. This can fill them with fear as they realize the cost, the time, the guilt and the uncertainty of the future. Adult children may be too ashamed to ventilate their feelings of resentment and frustration with the caregiving role. Sometimes, these suppressed emotions can result in verbal assaults, neglect, and even physical battering.

Nursing Issue

Elder abuse is of particular concern to nurses. As formal caregivers we are vulnerable to all the stresses inherent in that role. Many of us are informal caregivers, and if we are not now, we are bound to be so in some capacity in the future. We are also responsible and caring citizens. Nurses must be aware of the problem of abuse and neglect of the elderly and initiate programs to prevent it. It is our challenge to make elder abuse an issue to which government and other organizations must respond. As nurses we have been forerunners in the fight against child abuse and spouse abuse - can we do less for those who need us most?

Definition

There is no common definition of elder abuse and this presents a major problem in establishing a knowledge base. It is mandatory that researchers collaborate and agree on an acceptable definition of elder abuse. They must determine a classification system which will clarify the inconsistency and variation in the current definition.(3) The operational definition of elder abuse in this article is: Any act or behavior by a family member or person providing care (formally or informally) which results in physical or mental harm or neglect of an elderly person.

Categories

Elder abuse usually occurs in three main categories: physical abuse and neglect, psychosocial abuse and exploitation. Abuse is not limited to one incidence. It takes place in different situations and the reasons behind the abuse are varied. Examples include: infliction of actual physical pain, denial of physical and health related necessities of life, removal of the decision - making power, mental distress, isolation, and situations involving the dishonest use of an elder person's money or property.

Causes

No single factor has been identified as the cause of elder abuse. Theories overlap and abuse appears to be triggered by the interplay of several factors. Researchers agree that stress is present in families where elder abuse takes place. This stress may result from conditions existing within the particular family, the community or society at large. Bookin summarizes the variety of explanations which have been proposed and which include the following: developmental dysfunction; pathological problems; ageism and violence as a way of life; changes such as increased longevity, fewer family ties, greater demand on family resources; and family conflict.(4)

Prevalence

The extent of elder abuse in Canada, pending empirical investigation, is still underrecognized and undetermined. It has been estimated that as many as 100 000 elderly Canadians could be mistreated annually. The Manitoba Study in 1982 estimated that 2.2% of the 18 000 elderly persons living in that province and receiving care are experiencing abuse of some kind at the hands of caregivers.(5) The true incidence of abuse of an elderly person living in a family setting is difficult to identify and practically impossible to prove because the victim does not want to reveal the problem. Feelings of fear, guilt and embarrassment are involved. The victims cannot bring themselves to admit that abuse could happen in **their** family. Elders have come to the point of reporting abuse, only to find that they were not believed, because for some, there may be a history of confusion or dementia.

The Victim

The victim is usually a woman over the age of 75 years, with one or more physical and/or mental impairments. Other characteristics are social isolation and dependence on the caregiver. The victim may feel that they deserve the abuse and they may have been an abusive parent. The victim is passive and often feels powerless to control the situation.(6)

The Abuser

The abuser may be middle aged or elderly themself. The abuser tends to "blame" the victim, with whom he might also have a dependency relationship. The abuser may be experiencing some form of stress: unemployment; financial stress; marital discord; or substance abuse. The abuser has poor impulse control and may have been an abused child or come from a violent background.(7)

Indicators

No one characteristic automatically points to abuse or neglect of the elderly, rather nurses should look for clusters of factors which might indicate mistreatment. It is important to remember that some signs may in fact be due to the aging process. Observations which trigger further investigation include:

- elder has physical/mental limitations affecting ability for self care

- medical history does not coincide with presenting injuries
- postpones seeking medical treatment
- sores, injuries which have not been treated/partially healed
- history shows repeated incidents of unexplained "accidents"/injuries
- history of seeking medical attention from a variety of doctors/treatment centres
- evidence of: malnutrition, dehydration, overmedication, undermedication, muscle contractures, poor skin care, hygiene, bruises, hematomas, fractures.
- behavioral - attitudinal response of caregiver: appears fatigued, "blames" elder, responds defensively when questioned, excessively concerned, unconcerned, avoids physical, verbal, facial contact with elder or professional, treats elder like a child or nonperson.(7)
- behavioral - and attitudinal response of elder: passive, withdrawn, gives information reluctantly, anxious, fearful, changing speech pattern, avoids physical, verbal, facial contact with caregiver, professional.

Presence of high risk factors which precipitate elder abuse:

- **caregiver:** lack of knowledge of caregiver role/services available and how to access them/age/psychological/physical health of caregivers stress: multiple family problems/substance abuse/financial problems/lack of privacy/overcrowding/pressured into caregiving role (guilt)/changed life style/increasing needs and demands of elder/history of family violence/social isolation/lack of support network/role dissatisfaction/fear of growing old.
- **elder:** psychological, physical impairments/increasing dependency on caregiver/learned helplessness/substance abuse/social isolation/lack of support natural/meaningful losses, i.e., bereavement, loss of independence/role reversal/history of family violence/fear of institutionalization.

Gaining Access

How do we reach the elderly victim of abuse? How can we get through that closed front door? A massive communication blitz is necessary. Every possible channel must be utilized to get a message through to the victim and abuser that there are community supports to help them - what they are and how to access them. Some measures include postal alert, mail box flyers, pamphlets, TV and radio messages, hot lines, distress centres, information printed on grocery bags. All communication messages must be in the language of the target group. Support must be sought from those who come in contact with the elderly; those who know them and in turn are known by the elder person: bank clerks, hairdressers, utilities personnel, grocery clerks, bus drivers, clergy. A concerned third party could be the needed link, for example a neighbor may be aware that there is a problem but is uncertain how to approach it.

Other means of identifying the abused include hospital detection protocols done through the admitting or emergency departments. Such assessment protocols are excellent methods of identifying the physical, psychological, emotional and behavioral signs of abuse and or neglect. Nurses must have unlimited patience, understanding and compassion in questioning and seeking information from suspected abusers and their victims. The nurse's attitude and skills could determine the outcome of a resolution of the situation.

Intervention

Legislation: There is a need for changes to legislation dealing with abuse of the elderly. Human service workers are frequently "hamstrung" because there is no legal authority to intervene in suspected cases of elder abuse. The question of **Mandatory reporting** must be closely examined. Reporting will not solve the numerous societal and family situations underlying abuse. Services must be in place which will assist both the victim and the abuser.(8)

Advocacy: Nurses have an obligation to act as advocates for the elderly because they are often unable to articulate their needs and protect themselves. Nurses can also support citizen groups engaged in advocacy programs. For example, Concerned Friends of Ontario Citizens in Care Facilities, and the Patient's Rights Association.

Research is essential to determine the causes leading to abuse and to develop valid and reliable identification and assessment tools.

Education is needed to increase professional and public awareness of the elder abuse problem. Gerontological concepts must be included in the curricula at all levels of education from nursery school to university. Only by focusing on the strengths and basic rights of elderly people can positive attitudes be fostered. The victim must have **Medical intervention** for treatment of injuries - This could mean hospitalization or removal to a safer environment. **Protective Services** should be in place, for example legal intervention and guardianship. Coordination of **Community Support Systems** is necessary to ensure quality continuum care and help the family find their way through the bureaucratic maze. **Counselling** includes the victim, the abuser and family members because this problem affects everyone in the family unit. Use of a problem-solving process to teach effective caretaking roles must be made available. **Rehabilitation** and counselling should be ongoing.

A Shared Problem

As nurses we are caregivers. We face the same frustrations and unending burden of the caregiving role as informal caregivers in the community. We are just as vulnerable to the isolation and stress. We are just as in need of a support network. We must validate our peers working in geriatric centres. They have not received the recognition of those working in acute care settings and "high tech" areas. Yet the work they are doing requires just as much expertise and infinitely more "people skills". All the more reason to acknowledge the work they are doing because they are especially susceptible to discouragement and burn out. Just as we should lobby for more supports for informal caregivers so must we insist on more incentives for geriatric nurses. A big slice of the

health dollar is going into care for the elderly: part of this must be allocated to relieving the superhuman stress placed on nursing staff. If the field of geriatrics had a higher profile then more qualified people would be attracted to it. Staff shortage accounts for much of the elder abuse in institutions. How can you not restrain a client if there are only two nurses on a 40 bed unit? How can we not rush in feeding a client if there are 10 others waiting to be fed? How often do clients start to wander away at meal time when staff are trying feed other clients? Let us support geriatric nurses by lobbying for a better working environment, more in-service education, less bureaucracy and red tape and above all, more appreciation of their skills, their patience, their humanity in caring for the elderly.(9)

The subject of elder abuse generates feelings of sadness. We think of the tragic dilemma facing those who act in violence against someone they love or care for. We think of the pain endured by those affected by the process.(10) The problem has unfolded. We have the knowledge. Do we have the commitment to ensure that caregivers never cease to care?

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